DOCUMENT RESUME

ED 333 275 CG 023 429

TITLE Adolescence and Depression.
INSTITUTION Wisconsin Clearinghouse, Madison.
SPONS AGENCY National Inst. of Mental Health (DHHS), Rockville, MD.
PUB DATE 85
NOTE 35p.
PUB TYPE Information Analyses (070)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS Adolescent Development; *Adolescents; *Depression (Psychology); *Loneliness; *Self Concept; *Self Esteem; *Suicide
IDENTIFIERS *Identity Formation

ABSTRACT

This booklet begins with a poem written by an adolescent undergoing psychotherapy for depression, then goes on to describe what depression is and to examine sex and age differences related to depression. The difference between clinical depression and feeling blue is explained. Various therapies used in the treatment of depression are identified. The next section looks specifically at the changes that occur during adolescence, including physical, intellectual, and psychosocial changes. The next two sections focus on identity formation and implications for health professional of identity formation research. Manifestations of adolescent depression are listed and the association between adolescent depression and the adolescent's relationships with parents and peers is described. The next three sections examine depression and low self-esteem, adolescent loneliness, and suicide and the adolescent, respectively. Depression, suicide attempts, and suicide completion are compared for adolescents, young adults, and adults. The booklet concludes with a section on youth suicide prevention. (NB)

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ADOLESCENCE AND DEPRESSION

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Produced by the National Institute of Mental Health
Revised and reprinted by the Wisconsin Clearinghouse

National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857
U.S. Department of Health and Human Services
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

Wisconsin Clearinghouse
P.O. Box 1468
Madison, Wisconsin 53701–1468
608–263–2797

The Wisconsin Clearinghouse would like to thank Mary Conroy, prevention coordinator with the Division of Community Services, Wisconsin Department of Health and Social Services, for her contributions to this publication.

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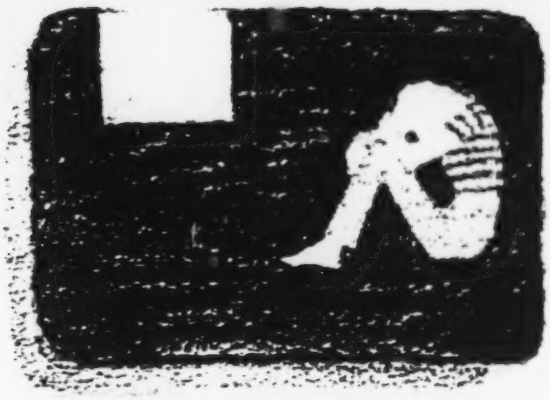
A View of the Adolescent's World of Depression

I see nothing but conflicts.
No meaning to life.
Yet no meaning to death.

Time passes by
    Minute by minute, hour by hour
        As I see myself die.
No one around to relieve my loneliness
    No one around me who cares.
Each day that passes
    I see nothing but conflicts.
No meaning to life,
    Yet no meaning to death.
I'm like a rope in tug-of-war
    Always being pulled upon.
Constant anger
    But all inside,
        As I see myself die.
Never any happiness
    Only hopelessness and helplessness.
Shall the day arrive soon
    Or shall I survive.
How can I live with a constant lie,
    For . . . , she must die.

Written by a 17-year-old high-school student currently undergoing psychotherapy for depression. Published in the public domain, with permission.



Depression—A General Survey

The major symptom of depression is a fairly prominent and persistent loss of pleasure and interest in former activities and pursuits.

WHAT IS DEPRESSION?

The major symptom of depression according to the American Psychiatric Association[1] is a fairly prominent and persistent loss of pleasure and interest in usual activities and pursuits. Feelings of sadness, hopelessness, and discouragement pervade the depressed individual. Symptoms usually accompanying the major symptom are:

- Decreased or increased appetite with significant weight change.
- Chronic insomnia or excessive sleepiness.
- Inability to sit still; pacing; hand wringing; pulling or rubbing the hair, skin, clothing or other objects; and outbursts of complaining or shouting. The reverse of this may occur in the form of slow body movements; low, slow, or monotonous speech; and poverty of speech or muteness.
- Decreased sex drive.
- Fatigue.
- Feelings of worthlessness, self-reproach, or excessive or inappropriate guilt.
- Inability to think or concentrate.
- Preoccupation with death or suicide.
- Abuse of alcohol and/or other drugs.

Other reactions to depression may be that of crying, feelings of anxiety, irritability, fear, brooding, excessive concern with physical health, panic attacks, phobias, hallucinations, and delusions.

The causes of depression are not completely understood.[2] The current view is that depression has multiple causes that may differ for individuals or groups, depending on life history, psychological makeup, inheritance factors, and biological vulnerability.

SEX DIFFERENCES

More than twice as many women as men experience depression. Approximately 18 to 23 percent of adult females and 8 to 11 percent of adult males have had a major depressive episode.[1] The typical depressed female is aged 25-40, married, and raising children.[3, 4]

AGE DIFFERENCES

Reactions to depression may differ within age groups.[1] Children may become anxious or clinging and refuse to go to school. Adolescent boys may become negative, antisocial, restless, grouchy, aggressive, or uncooperative. They may want to leave home, have school difficulties, dress carelessly, become emotional, be sensitive to rejection, or begin to use alcohol and drugs. (Symptoms of depression specific to adolescent girls are not given in the American Psychiatric Association manual.) Elderly people may have difficulty in concentrating, be easily distracted, have memory loss, be indifferent, or become disoriented. Careful examination will reveal the core symptoms of depression in these specific age groups.

WHAT'S THE DIFFERENCE BETWEEN CLINICAL DEPRESSION AND FEELING "BLUE" OR "DOWN?"

The term depression can be used to refer to several related, but distinct conditions.[3, 5] Depression can refer to a mood that all of us experience at one time or another in response to disappointments, frustrations, etc. It is part of the ups and downs of normal life. Depression can also refer to symptoms of sadness, loss of energy, inability to experience pleasure, feelings of helplessness, and bodily complaints that may be short-lived but that are outside the range of normal. Depression can also refer to a clinical syndrome which is characterized by depressed mood with associated features, persistence over time, and some impairment of functioning. Associated features may include appetite and sleep disturbances, loss of energy, feelings of pessimism, hopelessness, inability to experience pleasure, and thoughts of death and suicide. The depressive syndrome lasts at least several weeks and may last years.

TREATMENT

Psychotherapy, drug therapy, and electroconvulsive therapy (ECT) are used in treatment of depression.[2] Psychotherapy approaches include a range of individual, family, and group therapies. Drug therapy is prescribed to alleviate specific symptoms of depression. The drugs most commonly used, which produce different chemical reactions and effects, are the tricyclics, monoamine oxidase inhibitors, and lithium. ECT is usually used and found to be effective in severe depressions that do not respond to psychotherapy and/or drug therapy.

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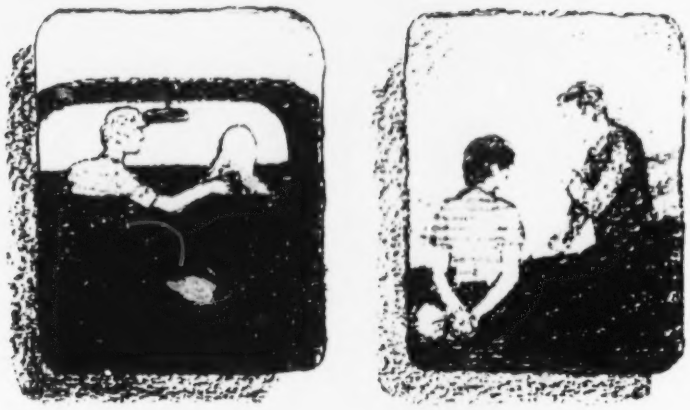

The Process of Adolescence

Adolescents undergo a shakeup physically, psychologically, emotionally, and socially.

The process of adolescence is conflicted, complicated, and demanding.[1] Adolescents undergo a shakeup physically, psychologically, emotionally, and socially. There are pressures from within (hormonal changes, bodily changes, sexual desires), and without (from peers—need for heterosexual relationships, social approval, acceptance; from parents—for maintenance of grades, restrictions on dress and behavior). It is a time of adaptation and integration into the broader society and achieving a degree of separation from family. Establishing one's own identity apart from parents is further complicated by conflicts between traditional and contemporary sex roles.

PHYSICAL CHANGES

Physically, the transition from child to adult is triggered by the production and secretion of hormones in the body which lead to the onset of puberty.[2] The physical growth and development that follows is extremely rapid and basically similar in sequence, with differences in timing depending on the individual's genetic makeup.

Generally, for both sexes, there is a marked increase in height and weight, appearance of acne, underarm hair growth, increased perspiration, appearance of pubic hair and enlargement of external genitals.

Changes for girls—breasts develop, waistlines narrow, hips widen, uteri and ovaries enlarge, ovulation and menstruation begin.
Changes for boys—facial hair emerges, the larynx enlarges, voices deepen, musculature develops, shoulders broaden, some breast enlargement is possible, sperm is produced, and the first ejaculation occurs.

Basically, the physical changes occurring during this period stimulate the transition from child to adult—turning boys into men and girls into women who are capable of reproducing a child. New feelings, sensations, and awareness of self and others are created by these changes and new coping skills must be learned.

INTELLECTUAL CHANGES

The intellectual changes are primarily cognitive[2] and vary from among individuals both in level of development and efficiency of use. In general there is a development of capacity and ability for:

- Dealing with abstractions and creating hypotheses
- Logical reasoning
- Complex problem solving
- Critical thinking
- Classification by category
- Increased memory skills

PSYCHOSOCIAL CHANGES AND ADJUSTMENT

Psychological and social changes and demands are many:[2]

- Achievement of appropriate gender role
- Acceptance of body image
- Greater independence from parents
- Responsible sexuality
- Academic goals
- Occupational preparation
- Establishment of values relating to marriage and parenthood

The external changes and demands confront the adolescent with the question: ***Who am I and Where do I want to Grow?*** It is a time of formation of identity—when one must find an orientation to life that fulfills personal needs and values and is also consistent with societal expectations.

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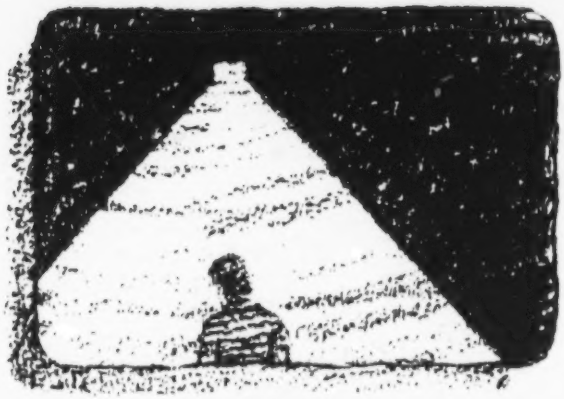

Identity Formation—Who Am I and Where do I Want to Grow?

"Deep down you are not quite sure that you are a man—or a woman—...that you will ever grow together again...that you really know who you are...or what you want to be ..."

Establishing a sense of personal identity—*Who Am I and Where Do I Want to Grow?*—is a psychological and social crisis for the adolescent. He or she is faced with the necessity of establishing an identity that is simultaneously in harmony with personal needs and desires and those of the immediate culture and society in which one lives.

To resolve the issue of "Who Am I and Where Do I Want to Grow?" the adolescent must confront and resolve numerous questions that are primarily related to his or her social role:

What do I believe?

What do I value?

What do I want in life? Education? Occupation? Marriage? Children?

What kind of friends do I make? What kind do I want?

What is my role as a female?

What is my role as a male?

How do I interact with the opposite sex? With the same sex?

How do I handle my emotions?

Do I want to get married?

Do I want to remain single?

Do I want to have children? How many? Girls? Boys? Or Both?

Do I want to become a nurse? A Doctor? A Lawyer? A Homemaker? Secretary? Engineer? Scientist?

The developmental model of Erik Erikson,[1,2] a recognized expert in psychological and social development, is one of the most comprehensive, thoroughly studied, and widely utilized outlines of human growth. Erikson maintains that the potent developmental crisis for the adolescent is that of attaining a sense of identity while overcoming identity confusion.

The adolescent is challenged "to be oneself" (or not to be) and to share being oneself with others. The adolescent must integrate all that he or she is—needs, desires, attributes—with existing open choices in friendships, roles, first sexual encounters, and more.

IDENTITY CONFUSION

In coping with the task of establishing a sense of who and what one is and wants to become, the adolescent may become confused. The confusion may occur if the task is too difficult; if he or she has been forced to assume an incompatible role; or a formerly chosen role is inappropriate for current needs, values and views.

The adolescent, according to Erikson, may react to the resulting confusion by running away—leaving schools and jobs, staying out all night, or withdrawing into "bizarre and inaccessible moods." Erikson maintains that recognition of the special dynamics and complexities of adolescence is important for early correction and treatment of this confusion. A tendency on the part of family and friends to type the individual as a delinquent—a "bum," a "queer," "off the beam," or similar demeaning and derogatory terms may result in a self-fulfilling prophecy; that is, he or she may ***become*** what others perceive and expect the individual to be.

The conflict can also result in a loss of identity through overidentification with heroes or cliques. An intolerance of "differences" of others may occur. Erikson[1] indicates it is important to understand (not necessarily to condone) that intolerance may be a necessary defense against identity confusion. It may be unavoidable at a time of life when

> "genital maturity floods body and imagination with all manners of drives, when intimacy with the other sex approaches and is on occasion forced on the youngster, and when life lies before one with a variety of conflicting possibilities and choices."

When faced with such identity confusion, adolescents may then cling together for support and solid grounding in a group identity.

Erikson[1] sees the formation of identity as a time of uncertainty—a time when

> Deep down you are not quite sure that you are a man . . . or a woman . . . that you will ever grow together again and be attractive, that you will be able to master your drives, that you really know who you are, that you know what you want to be, that you know what you look like to others, and that you will know how to make the right decisions without once and for all committing yourself to the wrong friend, sexual partner, leader or career.

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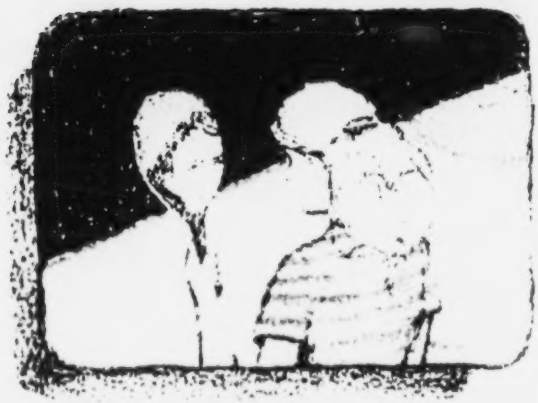

Identity Formation Research: Implications for Health Professionals

Courses in identity formation, consultation services, and exposure to adults as people who also struggle with life's complexities are suggested as a means of alleviating the turmoil and stress of adolescence.

Bernard,[1] professor of psychiatry at the University of Rochester, New York, has reviewed the research on identity formation during late adolescence and its relationship to overall adjustment, cognitive characteristics, academic performance, and gender.

OVERALL ADJUSTMENT, COGNITIVE CHARACTERISTICS, AND ACADEMIC PERFORMANCE

Adolescents who have attained a sense of identity as opposed to those having identity confusion have less anxiety, less alienation from others, more respect for authority, more internal control, higher self-esteem, higher grade-point averages, and higher scores on learning and perseverance. They are calm and nurturant toward peers and reflective in decisionmaking.

Conversely, adolescents having identity confusion compared to those who have attained a sense of identity have more anxiety, more alienation from others, less internal control, lower self-esteem, lower grade-point averages, and lower scores on learning and perseverance. They are hostile or furtive toward peers and impulsive in making decisions.

GENDER

There is an indication that identity formation for the male is more often associated with vocational choice, and that for the female with

affiliation or intimate relationships. This appears to be a reflection of powerful cultural expectations that emphasize autonomy or independence for the male and intimate relationships for the female. (Future research on the impact of female and male liberation from these stereotypes may show more similarity between the sexes.)

There is some indication that identity formation, sex-role orientation, and self-esteem are related. Females and males who have an androgynous orientation have higher self-esteem and identity achievement. The psychologically androgynous person is one who expresses both masculine and feminine characteristics, is both instrumental (task-oriented) and expressive (socioemotional), and is both assertive and yielding when the occasion calls for such behavior.[2, 3] Those having an undifferentiated sex-role orientation with lower expressive levels of masculine and feminine characteristics have lower self-esteem and higher levels of identity confusion.

Autonomy, independence, and assertiveness —traditionally masculine characteristics— are considered more crucial to identity formation than understanding and warmth —traditionally feminine characteristics.

IMPLICATIONS FOR HEALTH PROFESSIONALS

A "sense of identity" is important not only for the adolescent's current adjustment but as a foundation for later adjustment. Bernard suggests three areas of intervention as an aid in alleviating turmoil and stress:

1. Identity formation courses as part of the school program. The courses should be both didactic and experiential. Didactic courses should focus on adult development, and experiential courses should focus on the adolescent's individual progress in establishing a sense of identity.
2. Consultative intervention. Intervention techniques should emphasize, encourage, and facilitate the adolescent's definition of self.
3. Exposure to, and identification with, adults. Exposure should emphasize experience and identification with adults as complex human beings who also struggle with life issues. The issue for the adolescent then becomes one of a human struggle —not that of an isolated adolescent.

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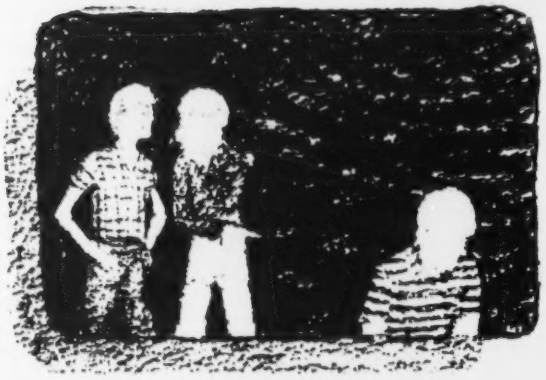

"Social abandonment" and "acting out" are particularly characteristic of adolescent depression.

Manifestations of Adolescent Depression

Few studies have been done to identify specific symptoms of depression in the adolescent. The high rate of depression and suicide in this group prompted Mezzich and Mezzich,[1] researchers from Ohio State and Stanford Universities, to develop the Face Valid Depressive Scale for Adolescents (FVDSA) as a means of identifying those factors specifically relevant to the world of adolescent depression.

Thirty-five items for the FVDSA scale were chosen from the Minnesota Multiphasic Personality Inventory (MMPI), a widely used and accepted clinical and research instrument. Symptoms judged to be specific to depression in adolescence and used as the basis for selection of the MMPI items were:

- Sadness
- Fluctuation between indifference and apathy on one hand and talkativeness on the other
- Anger and rage—typically expressed by verbal sarcasm and attack
- Sensitivity with inclination to overreact to criticism
- Feelings of insufficiency to satisfy ideals
- Poor self-esteem
- Feelings of helplessness and decreased peer support
- Intense ambivalence between dependence and independence
- Feelings of emptiness in life
- Restlessness and agitation
- Pessimism about the future

- Death wishes; suicide ideas, plans, and attempts
- Rebellious refusal to work in class or cooperate in general
- Sleep disturbance
- Increased or decreased appetite
- Weight gain or loss
- Somatic depressive equivalent (e.g. headache)

The selected MMPI items were then applied to the records of 212 adolescent psychiatric patients and factor analyzed. (Factor analysis is a statistical procedure that summarizes and explains underlying relationships of data.) The analysis revealed six core factors in depression. Those factors together with the main contents are as follows:

- Lack of self-confidence. Feelings of guilt, lack of energy, brooding, and sadness are also contained in this group.
- Social abandonment. Emptiness in life, death wishes, and social frustration are also contained in this group.
- Loss of interests. Difficulty in interpersonal communication is also contained in this group.
- Sadness. Weight change, grouchiness, frequent crying, and feelings of hopelessness are also contained in this group.
- Somatic symptoms. Disturbed sleep and feelings of loneliness are also contained in this group.
- Acting out. Desire to run away from home, aggressiveness, and lack of self-confidence are also contained in this group.

The two factors that are particularly characteristic of adolescent depression are social abandonment and acting out.

The other factors—loss of self-confidence, loss of interest, sadness, and somatic symptoms—are common to both adult and adolescent depression.

The use of alcohol and other drugs can be both a cause and effect of depression in young people. Adolescents may drink or use drugs in an attempt to combat feelings of depression, anxiety, low self-esteem, and loneliness. However, drug use by young people may complicate their problems—chronic health ailments, low self-esteem, and/or poor relationships with family and peers—and make it harder for them to cope. Put more simply: Some adolescents use drugs to cope with depression; at the same time, drug use by some adolescents results in severe depression. This intertwined relationship can result in a deepening cycle of mental illness and drug abuse.

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Depressive Mood in Adolescence: Parents, Peers, and Sex Differences

The most beneficial pattern for mental health in the adolescent appears to be a balance between involvement with peers and remaining close with parents.

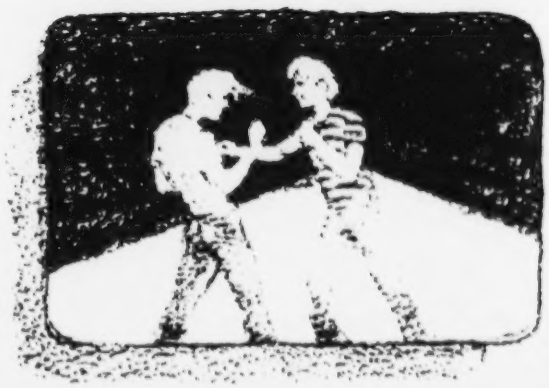
What are the specific factors associated with depressive mood, i.e., feelings of sadness and disappointment, in the adolescent? Kandel and Davies,[1] researchers from Columbia University and New York State Psychiatric Institute, gathered data on parental and peer factors and personal characteristics from 8,000 adolescents and their parents to shed some light on this question. Some of the factors found to be associated with adolescent depressive mood are:

- Low self-esteem.
- Minor delinquency.
- Strong peer orientation to exclusion of parental attachment. Isolation from peers also has detrimental consequences. High levels of attachment to both parents and peers were associated with lowest levels of depressive mood. The most beneficial pattern for mental health in the adolescent appears to be a balance between involvement with peers and maintenance of close parental ties.
- Adolescents reared in laissez-faire (non-interference) families.
- Adolescents reared in authoritarian (unquestioned obedience) families.

- Adolescents reared in a democratically oriented family are less likely to be depressed than those reared in either a laissez-faire or an authoritarian environment.
- Depressed parents.

SEX DIFFERENCES

Sex differences in adolescent depressive mood were strikingly large. Girls at age 14 through 18 experience consistently higher levels of depression than boys. Puberty may be a critical turning point for females. The smallest male/female differences in depression were recorded at age 13, with an increase occurring by age 14.



Delinquency was higher for boys than girls. The authors postulate that delinquent behavior in boys may be the equivalent of depressive mood in girls.

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Depression and Low Self-Esteem

"I'm a weakling"... "I'm no good."

WHAT IS SELF-ESTEEM?

Self-esteem is a judgment or estimate of one's value or worth—the extent to which one feels capable, significant, successful, and worthy.[1]

High self-esteem, or a positive estimate of one's worth, is characterized by self-confidence, independence, assertiveness, self-respect, pride, self-acceptance, expressiveness, and dominance. Low self-esteem, or a negative estimate of one's worth, is characterized by obedience, passivity, helplessness, inferiority, powerlessness, timidity, self-rejection, self-hatred, conformity, self-doubting, submissiveness, unworthiness, and self-punishment.

Coopersmith[1] cites four sources of self-esteem:

Power—the ability to influence and control others

Significance—acceptance, attention, and affection of others

Virtue—adherence to moral and ethical standards

Competence—successful performance in meeting demands for achievement

High self-esteem does not depend on success in all four sources; for example, one may have high self-esteem through being highly competent without being virtuous, significant, or powerful.

DEPRESSION AND LOW SELF-ESTEEM

Beck[2] indicates that one of the defining characteristics of depression is that of a negative self-concept associated with self-reproach

and self-blame. In a systematic study and description of depression symptoms, Beck breaks this down further to categories of ***self-dislike, low self-evaluation, self-blame and self-criticism***. Reactions in all of these may range from mild to moderate to extreme.

Self-dislike

Negative feelings about the self may take the form of an active dislike of oneself. In a mild state, self-dislike is characterized by feelings of disappointment:

"I've let everybody down . . . If only I had tried harder, I could have made the grade."

Moderate states of self-dislike are characterized by feelings of disgust:

"I'm a weakling" . . . "I'm no good."

Severe forms of self-dislike are characterized by self-hatred:

"I'm despicable" . . . "I loathe myself."

Low self-evaluation

Low self-evaluation, according to Beck, appears to be part of the depressed person's pattern of viewing oneself as lacking such attributes as "ability, performance, intelligence, health, strength, personal attraction, popularity or financial resources." The sense of self-deficiency is expressed by feelings of inferiority or inadequacy or in a complaint about lack of love or material possessions.

The mild form is characterized by an excessive reaction to errors or difficulties, with a tendency to see these as grounded in a defect or deficiency within oneself. The mild self-evaluation may be corrected by reasoning or presenting evidence to the contrary.

The moderate state is characterized by dwelling on deficiencies and failures with an exaggeration of errors and loss of self-confidence. Attempts to correct this with realistic evidence to the contrary usually meet with resistance.

The severe form is characterized by a drastic downgrading of the self. There are feelings of being totally worthless, inept, inadequate and impoverished—a sense of being a total failure and a burden to others. The severe negative self-evaluation is usually difficult to correct.

Self-blame and self-criticism

Self-blame and self-criticism are characterized by a tendency to take egocentric responsibility for adverse events, to blame the adversity on a deficiency within the self, and to criticize the self for having the deficiency.

The mild form is characterized by a tendency for self-criticism for failing to live up to one's own rigid standards of perfection. There is an inability to accept that it is human to err and a tendency to berate oneself for being dull or stupid.

The moderate form is characterized by harsh self-criticism for sub-standard behavior. There is an assumption of responsibility and blame for adversities unrelated to oneself.

The severe form is characterized by an extreme form of self-blame and self-criticism—viewing oneself as an object of public disapproval, like a social leper or criminal. This state, according to Beck, is exemplified by the following:

> "I'm responsible for the violence and suffering in the world. There's no way in which I can be punished enough for my sins. I wish you would take me out and hang me."

Low self-esteem and adolescent depression

The relationship between self-esteem and depression is well documented in studies with adults. Low self-esteem has been found to be prevalent among other factors in adolescent depression. Battle[3] designed a study with adolescents using self-esteem and depression measures only and confirms the specific strong association between self-esteem and depression in adolescents. Adolescents who scored higher on self-esteem measures also scored lower on depression.

Self-esteem and sex-role orientation

A growing number of studies indicate a relationship between self-esteem and sex-role orientation. In a study of 630 adolescents, Green[4] found a clear relationship between sex-role orientation, depression, and self-esteem. Males and females who choose an undifferentiated sex-role orientation (low expressive levels of masculine and feminine characteristics) have higher levels of depression and lower self-esteem than those choosing an androgynous sex-role orientation (expressive of both masculine and feminine characteristics). Low self-esteem was found to be a useful indicator of depression in adolescents; both low self-esteem and depression have a definite relationship to sex-role orientation.

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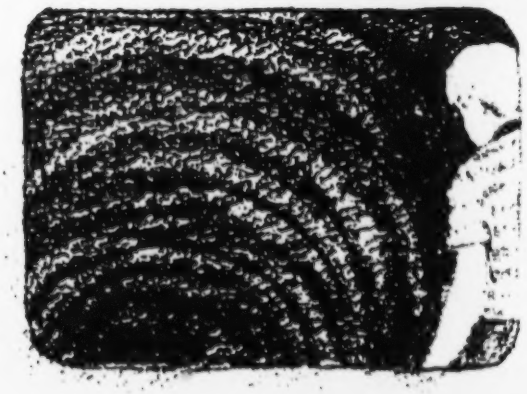

Adolescent Loneliness

The lonely adolescent has characteristics of low self-esteem, feelings of powerlessness, passivity, shyness, fear of risk taking, selfishness, and lack of interest in others.

There is some indication that adolescents experience more loneliness than other age groups. Findings indicate the age of onset is between 12 and 14 and reaches a maximum at age 16.

The position of the adolescent in today's society apparently contributes to a sense of loneliness, meaninglessness, powerlessness, and isolation. There is a role ambiguity in that adolescents are neither children nor adults. School failure can create a strong sense of rejection, lack of meaning and challenge can create boredom and apathy, social expectations may be unrealistic, and strong forces may oppose the struggle for independence and autonomy.

Loneliness in a study by Brennan[1] of the Human Systems Institute in Boulder, Colo., is seen broadly as a response to some perceived or vaguely experienced deficit in relationships. The major forms are emotional isolation, social isolation, spiritual loneliness, and existential loneliness.

Emotional isolation emerges from a lack of close intimate relating and stems from a loss of attachment figures. Associated feelings or mood state are a sense of emptiness, loss, unfulfillment, anger, and unhappiness.

Social isolation emerges from a lack of social connectedness or integration with peers or community. Associated feelings or mood

state are boredom, a sense of being on the outside and not belonging anywhere, and a desire to find new friends and move new places.

Spiritual loneliness emerges from a lack of meaning or significance in one's life. Associated feelings or mood state are boredom, aimlessness, emptiness, despair, hollowness, distractability, daydreaming, a feeling of being unchallenged and not using one's potential; or alternatively, rebellion, anger, frustration, and blaming.

Existential loneliness emerges from an awareness of the basic human condition of separateness, mortality, death, finiteness, and responsibility in one's life. Associated feelings or mood state are a sense of fear, dread, anguish, and terror.

The adolescent is confronted with considerable developmental changes in relationship with others. There is a necessary adjustment to losses or breaking off of critical attachments and the surfacing of new needs and desires for relations with others. A few of the developmental changes are:

- A loss of childhood identity and psychological social reference points, resulting in a sense of uncertainty and confusion, as well as an increased need for self-understanding, and reassurance and guidance from others.

- A loss of the attachment bond to parents, which can be critical and lead to emotional isolation.
- An increased awareness of separateness. Cognitive development in adolescence produces an increased awareness of "separateness" and mortality.
- New needs for heterosexual relationships derived from physiological and emotional maturing. The confidence and skills necessary to establish new relations may not be fully developed.

The characteristics of adolescents having high levels of loneliness are: low self-esteem — in the form of feeling worthless, unattractive, unpopular, and stupid; feelings of powerlessness; passivity in structuring leisure time activities; shyness and fear of risk taking; selfishness; and lack of interest in others.

Adolescents may cope or attempt to escape loneliness in a number of ways. Some dysfunctional ones are:

- Hero/heroine worship of celebrities. The absence of the hero or heroine and other disparities in this perceived relationship make this strategy unrewarding.
- Decreasing one's level of desire for relations. The healthy desire for relations may become permanently inhibited.
- Denying that loneliness exists. Denial may result in impaired development.
- Alternative gratifications—drugs, alcohol, "fun," and other forms of escape. These coping strategies may only lead to new problems, deeper levels of despair, or the erosion of the sense of self.

Some functional ways of coping are:

- Increasing one's social desirability.
- Making new/more friends.
- Exploring and making better use of existing social connections.

All of these may lead to social activities that increase acceptance and sense of belonging.

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Suicide and the Adolescent

Suicide is the third leading cause of death following accidents and homicide for teenagers and is increasing.

Seventy-five percent of deaths in teenagers are the result of accidents, homicide and suicide. Suicide ranks as the third cause of death for this group and is on the increase.

In 1979, 5,246 adolescents—4,245 males and 1,001 females—aged 15 through 24, committed suicide in the United States.[1] Male and female differences of the method of self-destruction are broken down as follows:

	Males	Females
Handguns, other firearms	2,705	511
Hanging, strangulation, suffocation	713	93
Drugs, other solid/liquid substance	225	232
Gases/vapors	275	62
Miscellaneous	327	103
Total	4,245	1,001

From 1968 to 1978 the suicide rate for individuals aged 15 to 19 increased from 5.0 to 7.9 per 100,000; the rate for males increased from 7.8 to 12.6 and that of females from 2.2 to 3.0. The 20 to 24 age group for both sexes showed an increase from 9.6 to 16.5 per 100,000; the rate for males increased from 14.9 to 26.8 and that of females from 4.7 to 6.3.

THEORIES OF ADOLESCENT SUICIDE

The basic causal theories of adolescent suicide are psychodynamic, developmental,

cognitive, sociological[2] and biological. It is important to point out that one theory alone is not sufficient to explain such a complex phenomenon as suicide. Each theory or model must be understood in an interactive context with other theories.

The ***psychodynamic theory***[2] emphasizes the influence of past events on the present and future. Suicidal behavior develops from the loss of love, deprivation, and possible rejection by significant people. Anger and resentment result, followed by feelings of guilt, which culminate in self-destructive behavior.

The ***developmental theory***[2] emphasizes the stress of adolescence. The adolescent period is a time of change, crisis, pressure, and tendency to impulsive overreaction. The precipitating event is the culmination of a longstanding sense of entrapment and rage and is usually associated with moving, changing schools, romantic breakup, death of a loved one, or divorce of parents.

The ***cognitive theory***[2] emphasizes the meaning of death for the adolescent. The adolescent is seen as having a sense of immortality—that death is reversible, not final. The adolescent's perspective is limited as a result of incomplete intellectual development as well as cultural attitudes and media that support the unreality of death.

The ***sociological theory***[2] emphasizes anomie, alienation, withdrawal, isolation, and loss of social contact. Anomie is characterized by a sense of weakening or disappearance of social guidelines—a lack of norms and structure in one's existence. Suicide results when a once-secure society is perceived as disintegrating and no longer dependable.

The ***biological theory***[3] emphasizes the biochemical correlates of suicide behavior and underscores the relationship of suicide behavior to affective disorders. Recent studies suggest there may be a deficiency in serotonin, a neurotransmitter, in people who commit suicide. Additional studies have found other biological abnormalities associated with suicidal behavior, which may prove to be helpful in the prediction and prevention of suicide.

ASSOCIATED BEHAVIOR CHANGES AND LIFE CRISES

Some of the changes in behavior and life crises[4, 5] associated with adolescent depression and suicide are listed below. It is important to point out mere presence does not necessarily imply suicidal behavior.

Behavior

Drastic change in personal appearance

Sleep change—insomnia or excessive sleepiness

Physical complaints—stomachaches, backaches, headaches, etc.

Decrease or increase in appetite with significant weight change

Inability to concentrate

Delusions, hallucinations

Loss of friends

Feelings of sadness, hopelessness, discouragement, of being "down in the dumps," having the "blues," and "not caring anymore"

Overwhelming sense of guilt/shame; feelings of worthlessness

Extreme fatigue, boredom, stammering, decrease in appetite

Social behavior changes—emotional outbursts compounded with crying or laughter, inability to sit still, excessive use of drugs, alcohol, sudden bursts of energy

Poor grades, truancy, disciplinary problems

Tearfulness

Preoccupation with death or suicide

Life crises

Death of loved one

Separation/divorce of family members

Injury or illness of self or a loved one

Remarriage of a parent

Pregnancy

Change in residence

Romantic breakup

Severe disappointment

Severe physical illness

Psychiatric illness

Precipitating Events

A study of 108 adolescent suicide attempts[4] over a 2-year period from 1977 to 1979 found that the adolescent's attempt to take his or her life is grounded in a combination of longstanding problems coupled with the impact of a recent precipitating event.

Fifty-two percent of precipitating events involved problems with parents; 30 percent involved problems with the opposite sex; 30 percent involved problems with school; 16 percent involved problems with brothers or sisters; and 15 percent involved problems with peers. Only 5 percent of the adolescents displayed psychotic symptoms such as disorientation, hallucinations or thought disturbances.

School adjustment can be a precipitating factor—poor grades, truancy, and disciplinary problems are associated with suicidal adolescents.

Family disruption plays an important part in adolescent depression and suicide behavior. Marital instability, economic stress, disruption of residence, and chronic, bitter conflict with parents can result in feelings of being unloved and rejected. A history of suicide attempts by family members and relatives is also prevalent.

Alcohol and other drugs also play a role in suicides by young people. Some adolescents use alcohol and other drugs as the means to commit suicide. Drug use also may increase depression and the possibility of suicide attempts. Thus chronic alcohol/drug abusers are at higher risk of suicide. And adolescents from families in which alcohol or drug abuse is a problem also are at higher risk for a wide range of mental health ailments.

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Depression, Suicide Attempts, and Suicide Completion: A Comparison of Adolescents and Young Adults

Suicidal individuals experience an increase in number of life crises, stress, and illness, coupled with a decrease in ability to cope and lack of support from others.

Hirschfeld and Blumenthal,[1] NIMH Center for the Study of Affective Disorders, reviewed the existing literature on depression and suicidal behavior to determine whether there are differences in risk (1) between depression and suicidal behavior in adolescents and young adults and (2) between these conditions in adolescence and young adulthood contrasted with those in adulthood. The factors considered are personality, life events, family and social history, and gender. The authors come to the following conclusions:

Adolescents/Young Adults

A clear severity dimension emerges for adolescents and young adults experiencing depression and attempting suicide. There is an increase in negative life events, self-undermining, and family stress and illness, especially psychiatric illness. There is a decrease in family supportiveness and one's ability to cope.

Those persons completing suicide are characterized as being more active, aggressive, and

impulsive than individuals experiencing depression or attempting suicide. There is a recurring and prevalent theme of confrontation over some event (poor grades, truancy, antisocial behavior), with subsequent humiliation. The number of females experiencing depression and attempting suicide is greater than that of males. The number of males succeeding at suicide is greater than that of females.

Adults

Adult findings parallel those for adolescents and young adults. Those persons experiencing depression and attempting suicide experience an increase in severity of life events, higher stress, more psychiatric and physical illnesses, a lack of support from family and significant others, and a decrease in ability to cope.

Suicide completers are also characterized as being more aggressive, with humiliating events preceding the suicide. Gender differences are similar to those of the adolescent/young adult group: More females than males experience depression and attempt suicide; more males than females succeed in completing suicide.

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Youth Suicide Prevention

As much as we might wish to do so, we cannot eliminate all suicides. However, through prevention and early intervention programs we can both reduce our feelings of helplessness and frustration and reduce the probability of some suicides occurring.

Effective prevention programs have the following characteristics: they alleviate conditions which adversely affect youth; they involve a collaborative effort by community agencies, schools, youth, and adults; they integrate prevention activities into family, classroom, school, and community life; they emphasize social skills development. Besides developing skills, these programs must affect attitudes and behaviors about youth suicides and mental health programs that can help head off these tragedies and encourage youth to seek professional help. Schools, especially, can positively affect youth development and can help identify the emotional, social and economic needs young people have. Schools should provide environments in which youth feel comfortable in sharing their thoughts and feelings with adults. Schools should help youth gain recognition for their accomplishments and help them learn how to cope with failure. Young people need to feel they have an active role in their school for making positive changes.

Adults and community institutions set the tone and develop the atmosphere in which youth learn attitudes and develop expectations about dealing with frustration and failure. Through community policies and programs we can provide youth with opportunities to develop living skills and responsibilities. For example, the business community is in a unique position to contribute a positive learning experience for its young employees. Public policies should focus not only on what youth shouldn't do but support ideas and

programs which encourage and allow youth to learn, gain respect for their achievements, and share in community responsibilities.

To initiate a youth suicide prevention program a community can begin by convening agencies, schools and key representatives from business, churches, law enforcement, government, health and young people to discuss the problem and how each can contribute to the program. It is essential that mental health, alcohol and drug, and youth agencies all coordinate their efforts to assure smooth referrals, case identification, and appropriate treatment services. A comprehensive community education program for all interested people then should be developed. It should address the myths about suicide (e.g., "if we talk about it we'll increase the problem"), identify the warning signs, and suggest responses that will help people provide effective preventive actions. Community mental health and crisis intervention service telephone numbers and addresses should be widely disseminated. This can be done as a cooperative community project to develop and distribute simple cards or handouts.

School suicide prevention programs should involve faculty, counselors, nurses, and administrators in planning and sponsoring workshops, reviewing materials to be used, and encouraging participation. Training should center on how to identify depression and suicide warning signs and what to do next. Written procedures should be established and disseminated on what staff should do when a student exhibits these warning signs. Young people also need to know what these warning signs are, where to get help, and how to respond quickly and effectively if a friend is in need. Young people should be a key target of school and community programs, because adolescents considering suicide are more likely to confide in a peer than in an adult. Community agencies and schools must work together if they are to succeed in this effort; a collaborative approach is critical.

Look at what already exists to help youth in your schools and community and build on that foundation. An existing student assistance, troubled student or student counseling program can provide the starting point. Meet with other groups and communities for additional ideas. Be willing to look at your community with an open mind so you can identify the underlying problems youth have and decide which aspects of their environment may need changing. Suicide prevention is a community problem that invites a unified community approach.

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Additional information may be obtained from the following staff of the National Institute of Mental Health, 5600 Fishers Lane, Rockville, Md. 20857:

Susan Blumenthal, M.D.
Head, Suicide Research Unit
Center for Studies of Affective Disorders
Division of Extramural Research, Room 10C-05
(301) 443-4524

Richard Brunstetter, M.D.
Acting Director
Division of Human Resources, Room 7-103
(301) 443-4257

John P. Docherty, M.D.
Acting Chief
Psychosocial Treatments Research Branch
Division of Extramural Research Programs, Room 10C-18
(301) 443-4527

Jacquelyn H. Hall, Ph.D.
Chief, Mental Health Education Branch
Division of Communications and Education, Room 15-81
(301) 443-4573

Robert Hirschfeld, M.D.
Chief, Center for Studies of Affective Disorders
Division of Extramural Research Programs, Room 10C-26
(301) 443-1636

Lenore Radloff
Statistician
Center for Epidemiologic Studies
Division of Biometry and Epidemiology, Room 18-105
(301) 443-2908

Hussain A. Tuma, Ph.D.
Chief, Clinical Research Branch
Division of Extramural Research Programs, Room 10C-24
(301) 443-4525

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WISCONSIN CLEARINGHOUSE
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Madison, WI 53701–1468
(608) 263–2797